

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> (x) HCP    ( ) IE    ( ) IC		<b>Response Timely Filed?</b> (X) Yes    ( ) No	
Requestor's Name and Address Metroplex Diagnostics 200 Wynnewood Village Dallas, TX 75224		MDR Tracking No.: M4-04-3536-01	
		TWCC No.:	
		Injured Employee's Name:	
Respondent's Name and Address                      BOX #: 47  American Casualty Company of Reading PA		Date of Injury:	
		Employer's Name: Texas Health Resources	
		Insurance Carrier's No.: 3A818536	

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
6/13/03	6/13/03	95900-26 x 4	0	-43.20
		95904-26 x 4	0	0
		95935-26 x 6	0	-47.70
		95900-27 x 4	179.20	179.20
		95904-27 x 4	179.20	179.20
		95935-27 x6	222.60	111.30
		99242	0	0
Total Amount Due				\$378.80

## PART III: REQUESTOR'S POSITION SUMMARY

The technical component shall not be reimbursed at a cost greater than 70% of the listed value. We submitted the technical and professional components of the NCV separately. The carrier is denying the technical component of the NCV stating that it is included in another procedure. The documented exam states in part, "The studies are performed on the left and the right side for comparative interpretation."

## PART IV: RESPONDENT'S POSITION SUMMARY

The EOB denials (G – Unbundling (292)) assert that the complete procedure has been reimbursed therefore the professional or technical component is not allowed separately. Full payment of \$292.20, the billed charges, was made for 95900, 95904 and 95935.

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

According to the documentation provided by the Requestor, Dr. Kogan performed the professional services and Dr. Souder performed the technical services. It is appropriate to bill these services separately with the proper modifiers per the 1996 MFG, Medicine Ground Rules (IV)(D).

Documentation reflects that motor studies were performed on the tibial and peroneal nerves of both lower extremities (2x2 = 4 units). Review of the EOB indicates full payment of \$120.00, the billed charge for 95900-26. The carrier's audit did not consider the modifier -26 as reflected on the HCFA. The CPT code 95900-26 is allowed \$64.00 x 30% x 4 units = \$76.80.

Per §413.016 and 134.800(f), the Commission has determined that an overpayment of \$43.20 for CPT code 95900-26 was

made to the Requestor and will order offset to the amount of additional reimbursement recommended in this Findings and Decision. Proper reimbursement for the technical component (modifier –27) of 95900 is \$64 x 70% x 4 units = \$179.20. Also, in accordance with the Medicine Ground Rules IV.B.2.b, “F” wave studies are reimbursed per extremity only if the compensable injury affected both extremities. If the contra-lateral extremity were tested to compare the affected and unaffected side, the comparison study would be considered to be part of the overall study. The documentation reports that the patient complained of left knee pain radiating to the gluteal region. The comparison study to the right leg is included with the “F” wave study to the left leg. Therefore only one “F” wave study is reimbursable in this dispute. The “H” study was also performed bilaterally and per the guidelines is allowed reimbursement for each extremity.

The professional component (modifier –26) was also overpaid by 3 units x \$53 x 30% = \$-47.70. Proper reimbursement for 95935-27 in this dispute is the three units at \$53.00 x 70% = \$111.30. In accordance with §413.016 of the Act and 134.800(f), the Commission will offset the overpayment towards the total amount of additional reimbursement recommended in this Findings and Decision as indicated in the above table.

#### PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **\$378.80**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

Ordered by:

Patti Lanfranco

June 30, 2005

Authorized Signature

Typed Name

Date of Order

#### PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative’s box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings  
P. O. Box 17787  
Austin, Texas, 78744  
or faxed to (512) 804-4011

A copy of this Decision should be attached to the request.

The party appealing the Division’s Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

#### PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative’s box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_

